

Interpreter Fees Reimbursement Voucher

CSB Name _____ Date _____

Contact Person _____ Phone Number _____

Date of Services _____

Services Provided: (Circle One)

Emergency/Crisis Services

Intake/Assessment

Psychiatric/Telepsychiatric Services

Therapy Services

Case Management

SPO Mental health Support Services

Psychosocial Services

Residential Services

Twelve Step Programs

Other: _____ (Specify)

Name of Interpreter: _____

Qualifications: (Circle as many as apply) RID: CSC, MCSC, CI, CT, RSC, CDI, OIC:C, IC, TC, SC:L; NAD: Level 5, Level 4; NCSA:TSC:\$, TSC:#, VQAS: Level IV, LEVEL III*. (*Provide brief justification) _____

Total Reimbursement Requested \$ _____
(50% of Interpreter Invoice)

CSB Signature

Reimbursement Authorized \$ _____

Date

State Coordinator Services for the Deaf, Hard of
Hearing, DeafBlind, and Late Deafened.